Duration: 00 hours, 35 minutes
Modifier: N/A

Document generated by: Richard J. Gale, PsyD 08/28/2020 08:34 AM

Indiana Government Center South
302 W. Washington Street
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DEPARTMENT OF CORRECTIONS
ADMINISTRATIVE NOTE

SITE: CIC
COMPLETED BY: Kelly K. Smith, RN 08/23/2020 11:36 AM

State of Indiana
Department of Correction
Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	08/23/2020 11:36 AM
VISIT TYPE:	Administrative Note

Tracking Information

Date of occurrence 08/23/2020
Time of occurrence 9:00 am

Issue

Offender signed consent and was given lab instructions.

Provider: Yoko Savino MD
Document generated by: Kelly K. Smith, RN 08/23/2020 11:36 AM

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State of Indiana
Department of Correction

Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
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Completed By	Jodean Ayres, RN
Date Completed:	07/19/2020
Offender Name:	JONATHAN RICHARDSON
DOB:	[redacted]
Name of Facility:	CIC
IDOC Number:	# 127630

DISABILITY CLASSIFICATION
Disability Code: A

Section A

A. _x_	No Disability. Offender is capable of performing activities of daily living.
B.	Offender has no useful vision even with best correction (e.g. completely blind, legally blind).
C.	Offender has a mobility of ambulatory impairment that substantially limits gross motor movement (e.g. paraplegia, stroke with hemiplegia).
D.	Offender is deaf or has profound hearing loss to an extent that the individual is unable to use hearing as a means of communication.

Date: 07/19/2020 10:05 AM
Provider: Yoko Savino MD
Document generated by: Jodean Ayres, RN 07/19/2020 10:05 AM

State of Indiana
Department of Correction

Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

Completed By:	Jodean Ayres, RN
Date Completed:	07/19/2020
Offender Name:	JONATHAN RICHARDSON
DOB:	[redacted]
Gender:	male
Name of Facility:	CIC
IDOC Number:	# 127630

FLU SCREENING FORM

In the last 24-48 hours, denies experiencing any flu symptoms.

Date: 07/19/2020 10:08 AM
Provider: Yoko Savino MD
Document generated by: Jodean Ayres, RN 07/19/2020 10:08 AM

State of Indiana
Department of Correction
Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

Jodean Ayres, RN

Completed By:	
Date Completed:	07/19/2020
Offender Name:	JONATHAN RICHARDSON
DOB:	[redacted]
Gender:	male
Name of Facility:	CIC
IDOC Number:	# 127630

HEAT STRESS QUESTIONNAIRE

Do you weight more than the weight indicates for your age and height on the weight table on the reverse of this form? no

Are you pregnant and in the second half of the pregnancy? no

Do you have emphysema? no

Do you have chronic obstructive lung disease? no

Do you have congestive heart failure? no

Do you have chronic kidney disease? no

Do you have cirrhosis of the liver? no

Do you take medication to relax the urinary bladder and help control urination? no

Do you take water pills (diuretic medication)? no

Do you take medication to control allergies? no

Do you take medication to control mental illness? no

Do you take medication to control the side effects of medication used to control mental illness? no

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Do you take medication to control intestinal spasm? no

Do you take any other medication that has been prescribed by a doctor? yes

Date: 07/19/2020 10:07 AM
Provider: Yoko Savino MD
Document generated by: Jodean Ayres, RN 07/19/2020 10:07 AM

DEPARTMENT OF CORRECTIONS
ANNUAL NURSE WELL ENCOUNTER

SITE: CIC
COMPLETED BY: Jodean Ayres, RN 07/19/2020 10:04 AM

State of Indiana
Department of Correction
Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	07/19/2020 10:04 AM
VISIT TYPE:	Nurse Visit

Vital Signs

Height

Time	ft	in	cm	Last Measured	Height Position
10:08 AM	5.0	11.0	0.0	02/08/2014	0

Weight/BSA/BMI

Time	lb	oz	kg	Context	BMI kg/m2	BSA m2
10:08 AM	215.2		97.613	dressed with shoes	30.01	

Blood Pressure

Time	BP mm/Hg	Position	Side	Site	Method	Cuff Size
10:08 AM	128/81	sitting	right	arm	automatic	adult

Temperature/Pulse/Respiration

Time	Temp F	Temp C	Temp Site	Pulse/min	Pattern	Resp/ min
10:08 AM	97.50	36.4		73	regular	16

Pulse Oximetry/FIO2

Time	Pulse Ox (Rest %)	Pulse Ox (Amb %)	O2 Sat	O2 L/Min	Timing	FiO2 %	L/min	Delivery Method	Finger Probe
10:08 AM	98		RA			21			

Measured By

Time	Measured by
10:08 AM	Jodean Ayres, RN

DEPARTMENT OF CORRECTIONS
ANNUAL NURSE WELL ENCOUNTER

SITE: CIC
COMPLETED BY: Jodean Ayres, RN 07/19/2020 10:04 AM

TB Review

Placed	Site	Side	Read	Result
10/12/2019	LA	left	10/14/2019	0 mm
07/21/2018	arm	right	07/23/2018	0 mm
07/21/2017	arm	left	07/23/2017	0 mm
07/22/2016	arm	left	07/24/2016	0 mm
05/08/2014		left	05/10/2014	0 mm
07/17/2012	arm	left	07/19/2012	0 mm
07/08/2007	RA		07/11/2007	0 mm

Past Positive Symptom Check
Reviewed and all responses negative.

Medical Observations
Tattoos/body piercing
Seen a doctor within the past 6 months

Physical Exam

Exam	Findings	Details
Constitutional	Normal	Well developed.
Eyes	Normal	Conjunctiva - Right: Normal, Left: Normal. Pupil - Right: Normal, Left: Normal.
Ears	Normal	Inspection - Right: Normal, Left: Normal. Hearing - Right: Normal, Left: Normal.
Nose/Mouth/Throat	Normal	External nose - Normal. Lips/teeth/gums - Normal.
Neck Exam	Normal	Inspection - Normal. Palpation - Normal. Thyroid gland - Normal.
Lymph Detail	Normal	No palpable cervical, supraclavicular, or axillary adenopathy.
Respiratory	Normal	Inspection - Normal. Auscultation - Normal. Effort - Normal.
Cardiovascular	Normal	Regular rhythm. No murmurs, gallops, or rubs.
Vascular	Normal	Pulses - Dorsalis pedis: Normal. Capillary refil - Less than 2 seconds.
Abdomen	Normal	Inspection - Normal. Auscultation - Normal.
Skin	Normal	Inspection - Normal.
Musculoskeletal	Normal	Visual overview of all four extremities is normal.
Extremity	Normal	No edema.
Neurological	Normal	Memory - Normal. Cranial nerves - Cranial nerves II through XII grossly intact. Sensory - Normal. DTRs - Normal.
Psychiatric	Normal	Orientation - Oriented to time, place, person & situation. Appropriate mood and affect. Normal insight. Normal judgment.

Review/Comments
Chronic disease current
Health maintenance current
Communicable disease testing current
Medical classification current
Disability status code current
Patient smokes 20.00 packs a year

DEPARTMENT OF CORRECTIONS
ANNUAL NURSE WELL ENCOUNTER

SITE: CIC
COMPLETED BY: Jodean Ayres, RN 07/19/2020 10:04 AM

Patient has not had a 30 pack year history of smoking cigarettes
Patient stopped smoking in 2000

Comments: Denies chest pain / SOB, no black or bloody stools, cleared for kitchen duty, testicular info signed, TB administered

Suicide Risk Screening

1. Arresting or transporting officer believes subject may be suicide risk. No
2. Lacks close family/friends in community. No
3. Experienced a significant loss within last 6 months (loss of job, relationship, death of close family member). Yes
4. Worried about major problems other than legal situation (terminal illness). No
5. Family member or significant other has attempted or committed suicide (spouse, parent, sibling, close friend, and lover). Yes
6. Has psychiatric history (psychotropic medication or treatment). Yes
7. Holds position of respect in community (i.e., professional, public official) and/or alleged crime is shocking in nature. Expresses feelings of embarrassment/shame. No
8. Expresses thoughts about killing self. No
9. Has a suicide plan and/or suicide instrument in possession. No
10. Has previous suicide attempts. (Note methods and dates). No
11. Expresses feelings there is nothing to look forward to in the future (feelings of helplessness and hopelessness). No
12. Shows signs of depression (crying, emotional flatness). No
13. Appears overly anxious, afraid or angry. No
14. Appears to feel unusually embarrassed or ashamed. No
15. Is acting and/or talking in a strange manner. Cannot focus attention; hearing or seeing things not there). No
16. History of substance abuse treatment? No

DEPARTMENT OF CORRECTIONS
ANNUAL NURSE WELL ENCOUNTER

SITE: CIC
COMPLETED BY: Jodean Ayres, RN 07/19/2020 10:04 AM

17. Is apparently under the influence of alcohol or drugs. No

18. If YES to #17, is individual incoherent or showing signs of withdrawal or mental illness. No

Total Yes's: 3

Comments:
#3 brother died, #5 sister committed and brother attempted, #10 by overdose

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Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
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Completed By:	Jodean Ayres, RN
Date Completed:	07/19/2020
Offender Name:	JONATHAN RICHARDSON
DOB:	[redacted]
Gender:	male
Name of Facility:	CIC
IDOC Number:	# 127630

MEDICAL STATUS CLASSIFICATION

Medical Code: G2

A.	Free of illness or injury; free of physical impairment; individuals with short term self-limiting condition requiring minimal surgical, medical, nursing or dental intervention limited to 30 days duration.
B.	Illnesses that do or will recurrently require skilled nursing care of any chronic physical or cognitive disability which requires on-going nursing care. Needs inpatient bed or immediate access to an inpatient bed.
C.	Renal failure requiring hemodialysis or peritoneal dialysis.
F.	Chronic physical or medical condition requiring frequent monitoring / surveillance, the on-site availability of licensed health care personnel twenty-four hours per day, or the inmate is frail or debilitated.
G. _ x _	Any stabilized, permanent or chronic physical or medical condition in which:
1.	Frequent monitoring/surveillance is not needed.
2. _ x _	The offender demonstrates an appropriate degree of knowledge and motivation and is able to perform self-care.
3.	A twenty (20) pound or greater weight lifting restriction is needed.
4.	TB prophylactic medication is being administered.
5.	Elderly (65 years of age and above)
6.	Adolescent (younger than 18 years of age)
I.	Short term self-limiting conditions of 31 to 180 days duration: conditions which may require a placement in an observation/short stay infirmary bed or requires that an inmate be placed in a negative pressure room.
J.	Pregnancy.

Date: 07/19/2020 10:05 AM

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Provider: Yoko Savino MD
Document generated by: Jodean Ayres, RN 07/19/2020 10:05 AM

State of Indiana
Department of Correction

Division of Medical and Clinical Healthcare Services
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302 W. Washington Street
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Facility: CIC

Date:	07/19/2020 10:04 AM
Offender Name:	JONATHAN RICHARDSON
DOB:	[redacted]
Gender:	male
DOC nbr:	# 127630

MENTAL STATUS CLASSIFICATION

BH Code: D

A. Free of mental illness

B. Psychiatric disorder that causes little functional impairment and requires infrequent psychiatric services. These services are routine in nature.

C. Psychiatric disorder that causes some functional impairment and requires frequent psychiatric and/or psychological services. These services may be routine and/or unplanned in nature and may involve mental health monitoring.

D. _x_ Psychiatric disorder that causes some impairment and requires frequent psychiatric and/or psychological services and/or the individual has a history of a serious suicide attempt while in a correctional setting. Services needed may be routine and/or unplanned in nature and may involve mental health monitoring.

E. Psychiatric disorder that causes significant functional impairment such that the individual is unable to function in a standard prison environment and requires structured psychiatric and/or psychological services. Services needed are provided in a specialized mental health unit. There is a good prognosis for improvement in functional impairment and eventual movement to a less restricted environment.

F. Psychiatric disorder that causes acute or chronic extreme functional impairment such that the individual is unable to function in a standard prison environment and/or causes significant risk of harm to the individual or others around the individual and requires extensive structured psychiatric and/or psychological services. Services needed are provided in a specialized mental health unit. There may be a poor prognosis for improvement in functional impairment and eventual movement to a less restricted environment.

Date: 07/19/2020 10:05 AM
Provider: Yoko Savino MD
Document generated by: Jodean Ayres, RN 07/19/2020 10:05 AM

State of Indiana
Department of Correction
Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
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Facility: CIC

PATIENT: JONATHAN RICHARDSON
DATE OF BIRTH: [redacted]
DATE: 07/08/2020 10:14 AM
VISIT TYPE: Chronic Care Visit

History of Present Illness:

1. asthma
   The initial visit date was 02/12/2008. Symptoms of asthma began in 1984. Pertinent negatives include awakening with cough, awakening with dyspnea, awakening with wheeze, dry cough, dyspnea at rest, dyspnea with intense exercise, dyspnea with moderate exercise, excessive sputum, hemoptysis, hoarseness, irregular heartbeat/palpitations, mucus plug production, oral thrush, pleuritic pain, post nasal drainage, productive cough, reflux, seasonal rhinitis symptoms, sinusitis, stridor, tremor after inhaler use and wheezing.

PROBLEM LIST:

Problem Description	Onset Date	Chronic	Clinical Status	Notes
Gender identity disorder of adulthood	06/17/2020	N		
Gastroesophageal reflux disease	02/19/2015	Y		Mapped from KBM Chronic Conditions table on 05/09/2016 by the ICD9 to SNOMED Bulk Mapping Utility. The mapped diagnosis code was Esophageal reflux, 530.81, added by Paul A. Talbot, MD, with responsible provider Paul A. Talbot MD. Onset date 02/19/2015.
Borderline personality disorder	05/04/2010	Y		Mapped from KBM Chronic Conditions table on 05/09/2016 by the ICD9 to SNOMED Bulk Mapping Utility. The mapped diagnosis code was Borderline personality disorder, 301.83, added by Darla Hinshaw, MD, with responsible provider . Onset date 05/04/2010; Axis II.
Recurrent major depressive episodes, mild	10/21/2019	N		

Problem List (not yet mapped to SNOMED-CT®):

RICHARDSON, JONATHAN 127630 [redacted] 07/08/2020 10:14 AM 115/182

Problem Description	Onset Date	Notes
Asthma	03/19/2007	
Polysubstance Dependence	01/17/2011	
major depression in remission	01/17/2011	
Nonspecific reaction to tuberculin skin test witho	02/01/2011	
Epilepsy	06/11/2015	

Allergies

Ingredient	Reaction	Medication Name	Comment
PENICILLINS	Rash		
IBUPROFEN	Rash		
CEFTRIAXONE SODIUM	SOB, chest pressure, rash	ROCEPHIN	Pt was given 0.5mg Epi x1 and NS IV w/ good results

Review of Systems

System	Neg/Pos	Details
ENMT	Negative	Hoarseness, oral thrush, post-nasal drainage and sinusitis.
Respiratory	Negative	Awakening with cough, awakening with dyspnea, awakening with wheezing, dry cough, dyspnea at rest, dyspnea with intense exercise, dyspnea with moderate exercise, excessive sputum, hemoptysis, mucus plug production, pleuritic pain, productive cough, stridor and wheezing.
Cardio	Negative	Irregular heartbeat/palpitations.
GI	Negative	Reflux.
Endocrine	Negative	Tremors.
Allergic/Immuno	Negative	Seasonal rhinitis symptoms.

Vital Signs

Height

Time	ft	in	cm	Last Measured	Height Position
10:15 AM	5.0	11.0	0.0	02/08/2014	0

Weight/BSA/BMI

Time	lb	oz	kg	Context	BMI kg/m2	BSA m2
10:15 AM	220.0		99.790		30.68	

Blood Pressure

Time	BP mm/Hg	Position	Side	Site	Method	Cuff Size
10:15 AM	130/83					

Temperature/Pulse/Respiration

Time	Temp F	Temp C	Temp Site	Pulse/min	Pattern	Resp/ min
10:15 AM	97.50	36.4		82		16

Pulse Oximetry/FIO2

Time	Pulse Ox (Rest %)	Pulse Ox (Amb %)	O2 Sat	O2 L/Min	Timing	FiO2 %	L/min	Delivery Method	Finger Probe
10:15 AM	98								

Measured By

Time	Measured by
10:15 AM	Ryan N. Wadsworth, RN

Physical Exam

Exam	Findings	Details
General Exam	Comments	Lung sound much improved after pt quit woking at the kitchen.
Constitutional	Normal	Well developed.
Eyes	Normal	Conjunctiva - Right: Normal, Left: Normal.
Ears	Normal	Inspection - Right: Normal, Left: Normal. Hearing - Right: Normal, Left: Normal.
Neck Exam	Normal	Inspection - Normal.
Respiratory	Normal	Inspection - Normal. Auscultation - Normal. Effort - Normal.
Cardiovascular	Normal	Regular rhythm. No murmurs, gallops, or rubs.
Vascular	Normal	Pulses - Dorsalis pedis: Normal. Capillary refill - Less than 2 seconds.
Abdomen	Normal	Inspection - Normal.
Musculoskeletal	Normal	Visual overview of all four extremities is normal.
Extremity	Normal	No edema.
Neurological	Normal	Memory - Normal. Cranial nerves - Cranial nerves II through XII grossly intact.
Psychiatric	Normal	Orientation - Oriented to time, place, person & situation. Appropriate mood and affect.

Assessment/Plan

#	Detail Type	Description
1.	Assessment	Asthma (493.90).
	Impression	Pt is stable, Mild intermittent, Estimate peak flow: 627 L/min education about inhaler use; triggers, and disease process d/w pt.
2.	Assessment	Gender identity disorder in adults (302.85).
	Impression	Side effects of medications d/w pt. Pt signed consent form for medications. will request FER for Estradiol 2 mg daily, Spironolaction 25 mg daily. Lab results reviewed with pt..
3.	Assessment	Hypercholesterolaemia (272.0).
	Impression	Pt wants to change diet, do more exercise, lose weight to improve FLP without medication. Pt is aware of risk of thrombus with use of estradiol. continue to monitor. If he cannot improve FLP, he agreed to resume medications..

Medications *(Added, Continued or Stopped today)*

Start Date	Medication	Directions	PRN Status	PRN Reason	Instruction	Stop Date
04/08/2020	Xopenex HFA 45 mcg/actuation aerosol inhaler	inhale 2 puff by inhalation route every 6 hours, as needed.	N			10/04/2020

Provider:

RICHARDSON, JONATHAN 127630 [redacted] 07/08/2020 10:14 AM 117/182

Savino, Yoko 07/08/2020 10:50 AM
Document generated by: Yoko Savino, MD 07/08/2020 10:49 AM

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Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
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Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	07/07/2020 2:04 PM
HISTORIAN:	self
VISIT TYPE:	Psychotherapy - Individual

Individual Counsel/Psych Prog Note

General

Program Name: Outpatient

Start time: 2:00 PM

End time: 00 hours, 55 minutes

Duration: 00 hours, 55 minutes

Individuals Present/Support Resources

Contact type:
Onsite
Individual present.

MENTAL STATUS EXAM
GENERAL OBSERVATIONS:
Generally normal
Appearance:Within normal limits
Build/Stature: Within normal limits
Posture: Within normal limits
Eye Contact: Average
Activity: Within normal limits
Attitude toward examiner: Cooperative
Attitude toward parent/guardian: Not Applicable
Separation (for children/adolescent): Not applicable

MENTAL STATUS:
Unremarkable
Mood: Euthymic
Affect: Full

Speech: Clear
Thought process: Logical
Perception: WNL
Hallucination: Denied None evidenced
Thought content: Within normal limits
Delusions: None Reported
Cognition: Within normal limits
Intelligence estimate: Average
Insight: Within normal limits
Judgment: Within normal limits

Subjective Information

Individual's report of progress towards goals/objectives since last session:
Ofd. seen for scheduled follow-up visit. Reports that she was written up and fired from her job for a verbal altercation with supervisor. Reports that she will be INP for 90 days and then will get back into the job/DOL program. Irritated that she was called over for labs for HRT r/t GD Dx without being told what it was for. Planning to move back to the faith-based housing unit where she had more friends/support. Denies SI or HI.

New issues/stressors/extraordinary events presented today: None reported

Goals, Objectives, and Interventions Addressed Today

Goal Today	Objective Today
Alleviate depressive symptoms	Identifies negative thinking supporting depression

Interventions/Methods Provided:
Psychologist assisted ofd. in applying language to her concerns and internal experiences. Explained the outcome of the recent gender dysphoria conference call, and the process of being evaluated for appropriateness for hormone replacement. Validated ofd's emotions, and explored her options re: housing and jobs.
Response to Interventions/Progress Toward Goals and Objectives:
Stable.

Current Assessment

Individual's progress: Some progress

Assessment:
Anxiety is significant and improved. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is significant and improved. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. Patient is responding to treatment plan. The patient is compliant with medications. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

Risk Assessment

CURRENT ENCOUNTER

Risk Assessments
Patient denies suicidal ideation, plan, intent, and/or attempt.
Patient denies property damage ideation, plan, intent, and/or attempt.
Patient denies homicidal ideation, plan, intent, and/or attempt.

RISK ASSESSMENT HISTORY

Risk	Current	Past	Documented	Event Date	Approximate Date	Ideation	Plan	Intent	Scale
Suicide	Denies		07/07/2020	07/07/2020	No				
Property	Denies		07/07/2020	07/07/2020	No				
Homicide	Denies		07/07/2020	07/07/2020	No				

Attempt	Planned/ Impulsive	Drug/Alcohol Influenced	Medically Treated	Plan Attempt Description

SAFETY MANAGEMENT PLAN
No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

Assessment/Diagnosis

AXIS IV
Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V
Current GAF: 67
Date: 07/07/2020.

Highest GAF: 68
Date: 02/25/2020.

Plan and Additional Information

Date	Order Description
07/21/2020	MHP follow-up for Ind Tx

SIGNATURES

Staff: Signed by Richard J. Gale, PsyD, HSPP on 07/10/2020

Behavioral Health Billing

Start time: 2:00 PM
End time: 2:55 PM
Duration: 00 hours, 55 minutes
Modifier: N/A

Document generated by: Richard J. Gale, PsyD 07/10/2020 02:09 PM

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State of Indiana
Department of Correction
Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	06/30/2020 12:01 PM
HISTORIAN:	self
VISIT TYPE:	Onsite Consult

Individual Counsel/Psych Prog Note

General

Program Name: Outpatient

HCR#: 7468

Start time: 10:30 PM

End time: 00 hours, 26 minutes

Duration: 00 hours, 26 minutes

Individuals Present/Support Resources

Contact type:
Onsite
Individual present.

MENTAL STATUS EXAM
GENERAL OBSERVATIONS:
Appearance:Within normal limits
Build/Stature: Within normal limits
Posture: Slumped
Eye Contact: Average
Activity: Within normal limits
Attitude toward examiner: Cooperative
Attitude toward parent/guardian: Not Applicable
Separation (for children/adolescent): Not applicable

MENTAL STATUS:
Mood: Depressed
Affect: Full

Speech: Clear
Thought process: Logical
Perception: WNL
Hallucination: Denied None evidenced
Thought content: Depressive Self-Deprecatory
Delusions: None Reported
Cognition: Within normal limits
Intelligence estimate: Average
Insight: Within normal limits
Judgment: Within normal limits

Subjective Information

Individual's report of progress towards goals/objectives since last session:
Offender Richardson was seen by MHP in her office for HCR #7468 dated 06/28/2020 and received/screened as routine on 06/29/2020 stating, "I'm having issues with the loss of my brother and dealing with the stresses of work and need to speak to someone about it. Preferrably not Wilson." She presented as tearful throughout the visit and reported feeling overwhelmed by emotion as a result of having multiple stressors coincide including the death of her brother and the subsequent complete loss of a

New issues/stressors/extraordinary events presented today: New issue resolved, no update required

Explanation: support system outside of prison. Offender Richardson shared that she was written up at work and realizes she should have taken some time off to process the loss rather than pushing herself emotionally. She denied SI and SIB.

Goals, Objectives, and Interventions Addressed Today

Goal Today	Objective Today
Alleviate depressive symptoms	Identifies negative thinking supporting depression
Alleviate depressive symptoms	Verbalizes increased feelings of self worth

Interventions/Methods Provided:
MHP utilized active and reflective listening to provide a safe, nonjudgmental environment in which the offender could share and explore mental health concerns. MHP reviewed the 5 stages of grief as well as myths about grief and loss. MHP taught the offender worry postponement and anxiety decision tree techniques to assist her in managing worry and stress regarding release now that her support system is gone. MHP reflected feelings of guilt and disappointment that Offender Richardson had been unable to repair her relationship with her brother prior to his death. MHP recommended follow-up with Dr. Gale for their regularly scheduled appointment next week.
Response to Interventions/Progress Toward Goals and Objectives:
Offender was cooperative, engaged, and receptive to feedback from MHP.

Current Assessment

Assessment:
Anxiety is significant. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is significant. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. Patient is responding to treatment plan. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

Risk Assessment

CURRENT ENCOUNTER

Risk Assessments

Patient denies suicidal ideation, plan, intent, and/or attempt.
Patient denies property damage ideation, plan, intent, and/or attempt.
Patient denies homicidal ideation, plan, intent, and/or attempt.

RISK ASSESSMENT HISTORY

Risk	Current	Past	Documented	Event Date	Approximate Date	Ideation	Plan	Intent	Scale
Suicide	Denies		06/30/2020	06/30/2020	No				
Property	Denies		06/30/2020	06/30/2020	No				
Homicide	Denies		06/30/2020	06/30/2020	No				

Attempt	Planned/ Impulsive	Drug/Alcohol Influenced	Medically Treated	Plan Attempt Description

SAFETY MANAGEMENT PLAN
No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

Assessment/Diagnosis

AXIS IV
Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V
Current GAF: 68
Date: 06/11/2020.

Highest GAF: 68
Date: 02/25/2020.

Plan and Additional Information

Date	Order Description
07/07/2020	MHP follow-up for Grief/Loss

SIGNATURES

Staff: Signed by Sara L Evans, MHP, MA, LMHC on 07/02/2020

Behavioral Health Billing

Start time: 10:30 PM
End time: 10:56 PM
Duration: 00 hours, 26 minutes

Modifier: N/A

Document generated by: Sara L. Evans, MHP 07/02/2020 03:09 PM

Indiana Government Center South
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State of Indiana
Department of Correction
Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

Facility: CIC

PATIENT: JONATHAN RICHARDSON
DATE OF BIRTH: [redacted]
DOC #: 127630
DATE: 06/23/2020 9:45 AM
VISIT TYPE: Chart Update

Nurse Visit

Reason for visit: FASTING LAB DRAW CONSENT

Statement of complaint (in patient's words): FASTING LAB DRAW CONSENT
OFFENDER REFUSED LAB DRAW
SIGNED REFUSAL FORM

Nurse Protocols:
Review/Comments
Patient smokes 20.00 packs a year

Medications

Medication	Sig	PRN Status	PRN Reason	Comment
Xopenex HFA 45 mcg/actuation aerosol inhaler	inhale 2 puff by inhalation route every 6 hours, as needed.	N		

Orders

Status	Order	Timeframe	Frequency	Duration	Stop Date
ordered	CBC WITH DIFF				
ordered	COMPREHENSIVE METABOLIC PANEL				
ordered	ESTRADIOL				
ordered	LIPID (CARDIAC) PANEL(INCL CHOLESTEROL, TRIG, HDL, LDL)				
ordered	PROLACTIN				
ordered	TESTOSTERONE, TOTAL				

General Comments

WILL R/S LAB APPT. PT WILL BE INFORMED THAT THESE LABS MUST BE DONE IN ORDER TO START GD TX SAFELY
FER approved for baseline prolactin, estradiol and testosterone levels to review with new GD Dx at upcoming CCC

Document generated by: Tina Collins, RN 06/23/2020 03:45 PM

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BEHAVIORAL HEALTH TESTING RESULTS

Patient:	JONATHAN RICHARDSON
Date of Birth:	[redacted]
Date:	06/17/2020 12:30 PM
Visit Type:	Psychological Testing

Behavioral Health Testing Summary

Minnesota Multiphasic Personality Inventory (MMPI-2)

MMPI-2 was administered as part of an ongoing evaluation for gender dysphoria. Ofd. reports identifying as a transgender woman and requests gender-affirming hormone treatment. Lingering concerns over the offender's history of mental health diagnosis and treament and her history of serious self-mutilation, self-harm, and suicidal behavior prompted the suggestion that the MMPI-2 be administered to help with identifying potential contraindications to diagnosing and treating gendr dysphoria.

Validity scales indicate the the offender approached testing in an attentive manner, and responses were very consistent throughout the test. There is evidence that she responded in a way that likely exaggerated mental health concerns, but it may have been unconscious/unintentional. The offender knew that this test was being administered as part of the evaluation procedure for a diagnosis and treatment that are emotioanlly important to her, and it is likely that her responses were unconsciously exaggerated in response to her desire for the evaluation to have favorable results. She exhibited a moderate level o fgeneral emotional distress, but the pofile indicates that she is generally able to adequately cope with this.

The profile of clinical scales is similar to profiles produced by people with a history of antisocial behavior, difficulty with the law, and serious family problems. They may come from a very destructive family background and blame their family for their problems. People with similar profiles may tend to be manipulative in interpersonal relationships, may often feel angry, irritable, impatient, stubborn, and hotheaded, and may be seen as rebellious, nonconforming, and hostile to authority. Others may frequently describe them as brooding, resentful, withdrawn, critical, and argumentative. They are likely to feel depressed, uncertain about the future, unsupported by others, and empty, with periodic thoughts of suicide possible.

People producing MMPI-2 profiles like Richardson's may be seen as suspicious, guarded, or paranoid. They may lead a schizoid lifestyle, go to lengths to avoid being taken advantage of, exhibit eccentric behavior, and be quite sensitive to the opinions of others. They may by likely to feel mistreated and blame others for problems or failures. They often meet criteria for diagnosis of a personality disorder, especially narcissistic, antisocial, and/or borderline.

There is some indication that people with this profile may be more prone to sexual deviation or sexual preoccupation. They may exhibit sexual immorality, including behaviors like pedophilia, rape, or sexual sadism. Richardson's responses to items on the test that are sensitive to traditional gender roles indicate that she likely holds strongly traditional feminine interests.

In regard to emotional functioning, Richardson's profile suggests that she may experience frequent emotional distress, anxiety, and sleep disturbance. She likely feels dissatisfied with romantic relationships. There is some acknowledgment of a history of substance abuse and/or acting out. There are consistent incidations in the profile of sadness, dysphoria, introversion, social withdrawal, and poor general adjustment/coping skills.

At the time of testing, Richardson has the following mental health diagnoses: major depressive disorder, recurrent, mild and borderline personality disorder. Her family history, emotional functioning, and behavior, and this writer's observations of her, are quite consistent with the MMPI-2 profile presented here. The diagnosis of gender dysphoria is being added to the offender's chart at this time based on the gender dysphoria evaluations that have been conducted, and it is further supported by this testing. Moreover, this test does not appear to give any indication of currently undiagnosed psychopathology that would better explain the offender's transgender identity (e.g., delusional thinking, hallucinations, etc).

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Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	06/17/2020 12:30 PM
VISIT TYPE:	Onsite Consult

Individual Counsel/Psych Prog Note

General

Program Name: Outpatient

Start time: 12:00 PM

End time: 00 hours, 30 minutes

Duration: 00 hours, 30 minutes

Individuals Present/Support Resources

Contact type:
Phone conversation
Individual not present.

Contact type:
Others Present: Dr. Crystal Mehta, Dr. Deanna Dwenger, Dr. Ellen Keris, & Dr. Corissa Dionisio

Subjective Information

Individual's report of progress towards goals/objectives since last session:
Gender dysphoria case conference call. See below for details. Ofd. being diagnosed with gender dysphoria and referred for evaluation for hormone therapy.

Risk Assessment

SAFETY MANAGEMENT PLAN
No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

Assessment/Diagnosis

AXIS IV
Severity: Moderate

Problem Type	No/Yes	Description
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated
Primary Support Group	Yes	Very little external support

AXIS V
Current GAF: 68
Date: 06/11/2020.

Highest GAF: 68
Date: 02/25/2020.

Plan and Additional Information

Plan/Additional Information:
A conference call was held today to discuss the offender's continuing request to be started on hormone therapy for gender dysphoria. Present on the call were Dr. Crystal Mehta (Regional Director of Psychiatry), Dr. Deanna Dwenger (Regional Director of Mental Health), Dr. Ellen Keris (Associate Regional Director of Mental Health), Dr. Richard Gale (treating psychologist), and Dr. Corissa Dionisio (psychiatrist). Dr. Gale and Dr. Dionisio presented summaries of their assessments of Richardson's history and presentation. The group discussed the indications for treatment and the remaining concerns about possible contraindications to intervention.

Primary among the concerns that were raised were Richardson's history of self-harm, self-mutilation, and drastic changes in physical appearance. Richardson's arms are covered in self-inflicted burn scars, she is missing joints from fingers from intentionally cooking them in a prison hot pot, and her head and face have been decorated with extensive tattooing. There was some concern that hormone treatment and the gender-affirming surgery that Richardson says she would eventually like to pursue may represent steps in the evolution over time of self-mutilating behaviors. However, Richardson has been free from any self-harm behavior for several years and has been relatively stable without psychotropic medication for over nine years. The results of Richardson's MMPI-2 were reviewed, and they do not raise any additional concern regarding contraindications to treatment. Richarson's symptoms of gender dysphoria do not appear to be better explained by other diagnosed or undiagnosed psychopathology.

Another concern discussed was that there may be some secondary gain to be had by pursuing this treatment, and that it is being pursued for that reason rather than genuine gender dysphoria. Richardson self-identifies as a "master manipulator," causing concern that she is "saying the right things" to be diagnosed and treated but is not being truthful. However, after discussing this concern, no secondary gain could be identified.

The case conference concluded that Offender Richardson appears to meet the DSM-5 criteria for diagnosis of gender dysphoria and the WPATH Standards of Care eligibility criteria for feminizing hormone therapy. The potential risks and benefits of recommending hormone treatment were discussed, and it was decided that there would be greater risk in not recommending treatment at this time. Richardson has a history of being compliant with medical providers' treatment recommendations, and there is a high likelihood of future compliance.

Per this case conference meeting, Dr. Gale is adding the diagnosis of gender dysphoria to Offender Richardson's records at this time, and Dr. Mehta will make a referral to primary care for evaluation for hormone therapy.

SIGNATURES

Staff: Signed by Richard J. Gale, PsyD, HSPP on 06/18/2020

Behavioral Health Billing

Start time:	12:00 PM
End time:	12:30 PM
Duration:	00 hours, 30 minutes
Modifier:	N/A

Document generated by: Richard J. Gale, PsyD 06/18/2020 04:14 PM

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Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	06/11/2020 10:00 AM
HISTORIAN:	self
VISIT TYPE:	Onsite Consult

Individual Counsel/Psych Prog Note

General

Program Name: Outpatient

Start time: 10:00 AM

End time: 00 hours, 30 minutes

Duration: 00 hours, 30 minutes

Individuals Present/Support Resources

Contact type:
Onsite
Individual present.

MENTAL STATUS EXAM
GENERAL OBSERVATIONS:
Generally normal
Appearance:Within normal limits
Build/Stature: Within normal limits
Posture: Within normal limits
Eye Contact: Average
Activity: Within normal limits
Attitude toward examiner: Cooperative
Attitude toward parent/guardian: Not Applicable
Separation (for children/adolescent): Not applicable

MENTAL STATUS:
Unremarkable
Mood: Euthymic
Affect: Full

Speech: Clear
Thought process: Logical
Perception: WNL
Hallucination: Denied None evidenced
Thought content: Within normal limits
Delusions: None Reported
Cognition: Within normal limits
Intelligence estimate: Average
Insight: Within normal limits
Judgment: Within normal limits

Subjective Information

Individual's report of progress towards goals/objectives since last session:
Ofd. seen for scheduled follow-up visit. She reports that she has spoken to another offender who is going through gender dysphoria diagnosis and treatment, and she is now more comfortable that she is not being brushed off or forgotten about. The other offender reportedly told her about her own experience, which echoed Richardson's experience in a lot of ways. She then talked about some world events that are occurring right now, including protests, riots, pandemics, etc. Denies SI/HI.

New issues/stressors/extraordinary events presented today: None reported

Goals, Objectives, and Interventions Addressed Today

Goal Today	Objective Today
Alleviate depressive symptoms	Identifies negative thinking supporting depression

Interventions/Methods Provided:
Ofd. engaged in discussion with Richardson about her growing comfort that she is receiving adequate consideration and care for her concerns around gender identity. Updated her on the progress of scheduling a follow-up conference call to discuss her request for hormone therapy. Challenged negative and biased thinking regarding some of the world events that offender is seeing on television and helped her gain a broader perspective on the world and the current state of affairs. Discussed her difficulty maintaining perspective on this since she had a limited viewing window out to the larger world because of being incarcerated.
Response to Interventions/Progress Toward Goals and Objectives:
Stable. Improved mood relative to last visit.

Current Assessment

Individual's progress: Good progress

Assessment:
Anxiety is not significant. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is improved. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. Patient is responding to treatment plan. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

Risk Assessment

CURRENT ENCOUNTER

Risk Assessments
Patient denies suicidal ideation, plan, intent, and/or attempt.
Patient denies property damage ideation, plan, intent, and/or attempt.
Patient denies homicidal ideation, plan, intent, and/or attempt.

RISK ASSESSMENT HISTORY

Risk	Current	Past	Documented	Event Date	Approximate Date	Ideation	Plan	Intent	Scale
Suicide	Denies		06/11/2020	06/11/2020	No				
Property	Denies		06/11/2020	06/11/2020	No				
Homicide	Denies		06/11/2020	06/11/2020	No				

Attempt	Planned/ Impulsive	Drug/Alcohol Influenced	Medically Treated	Plan Attempt Description

SAFETY MANAGEMENT PLAN

No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

Assessment/Diagnosis

AXIS IV

Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V

Current GAF: 68

Date: 06/11/2020.

Highest GAF: 68

Date: 02/25/2020.

Plan and Additional Information

Date	Order Description
07/02/2020	MHP follow-up for Ind Tx

SIGNATURES

Staff: Signed by Richard J. Gale, PsyD, HSPP on 06/17/2020

Behavioral Health Billing

Start time: 10:00 AM
End time: 10:30 AM
Duration: 00 hours, 30 minutes
Modifier: N/A

Document generated by: Richard J. Gale, PsyD 06/17/2020 12:50 PM

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Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	05/19/2020 1:00 PM
HISTORIAN:	self
VISIT TYPE:	Onsite Consult

Individual Counsel/Psych Prog Note

General

Program Name: Outpatient

Start time: 1:04 PM

End time: 00 hours, 51 minutes

Duration: 00 hours, 51 minutes

Individuals Present/Support Resources

Contact type:
Onsite
Individual present.

MENTAL STATUS EXAM
GENERAL OBSERVATIONS:
Generally normal
Appearance:Within normal limits
Build/Stature: Within normal limits
Posture: Within normal limits
Eye Contact: Average
Activity: Within normal limits
Attitude toward examiner: Cooperative
Attitude toward parent/guardian: Not Applicable
Separation (for children/adolescent): Not applicable

MENTAL STATUS:
Unremarkable
Mood: Euthymic
Affect: Full

Speech: Clear
Thought process: Logical
Perception: WNL
Hallucination: Denied None evidenced
Thought content: Within normal limits
Delusions: None Reported
Cognition: Within normal limits
Intelligence estimate: Average
Insight: Within normal limits
Judgment: Within normal limits

Subjective Information

Individual's report of progress towards goals/objectives since last session:
Ofd. seen for scheduled follow-up therapy visit. Ofd. identifies as a transwoman. She reports things are going along about the way they always do. She is becoming more impatient and frustrated regarding the slow movement of her request to be given a diagnosis of gender dysphoria and referred for hormone treatment. She would request that the process move along now that she has completed the testing requested of her. Denies SI or HI.

New issues/stressors/extraordinary events presented today: None reported

Goals, Objectives, and Interventions Addressed Today

Goal Today	Objective Today
Determine whether the offender meets criteria for gender dysphoria / determine appropriate treatment	Gather history and report of past and present symptoms that may support a diagnosis of gender dysphoria

Interventions/Methods Provided:
Provided empathic listening and validation. Attempted to explain the process of diagnosis and referral, and the factors about this offender's particular presentation that make it more difficult to make a clear determination about the way to proceed. Educated the offender about where we are in the current process and what the next steps are, and agreed to keep her informed of any new developments.
Response to Interventions/Progress Toward Goals and Objectives:
Stable.

Current Assessment

Individual's progress: Minimal progress

Assessment:
Anxiety is not significant. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is not significant. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. Patient is responding to treatment plan. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

Risk Assessment

SAFETY MANAGEMENT PLAN
No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

Assessment/Diagnosis

AXIS IV
Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V
Current GAF: 68
Date: 05/19/2020.

Highest GAF: 68
Date: 02/25/2020.

Plan and Additional Information

Date	Order Description
06/09/2020	MHP follow-up for Ind Tx

SIGNATURES

Staff: Signed by Richard J. Gale, PsyD, HSPP on 06/05/2020

Behavioral Health Billing

Start time:	1:04 PM
End time:	1:55 PM
Duration:	00 hours, 51 minutes
Modifier:	N/A

Document generated by: Richard J. Gale, PsyD 06/05/2020 11:25 AM

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State of Indiana
Department of Correction

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Indiana Government Center South
302 W. Washington Street
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Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	04/28/2020 3:18 PM
HISTORIAN:	self
VISIT TYPE:	Onsite Consult

Individual Counsel/Psych Prog Note

General

Program Name: Outpatient

Start time: 2:10 PM

End time: 00 hours, 50 minutes

Duration: 00 hours, 50 minutes

Individuals Present/Support Resources

Contact type:
Onsite
Individual present.

MENTAL STATUS EXAM
GENERAL OBSERVATIONS:
Generally normal
Appearance:Within normal limits
Build/Stature: Within normal limits
Posture: Within normal limits
Eye Contact: Average
Activity: Within normal limits
Attitude toward examiner: Cooperative
Attitude toward parent/guardian: Not Applicable
Separation (for children/adolescent): Not applicable

MENTAL STATUS:
Unremarkable
Mood: Euthymic
Affect: Full

Speech: Clear
Thought process: Logical
Perception: WNL
Hallucination: Denied None evidenced
Thought content: Within normal limits
Delusions: None Reported
Cognition: Within normal limits
Intelligence estimate: Average
Insight: Within normal limits
Judgment: Within normal limits

Subjective Information

Individual's report of progress towards goals/objectives since last session:
Ofd. present for scheduled therapy visit. She inquired about the results of her MMPI, scoring for which was just sent to the psychologist today. The remainder of the session was spent examining and providing initial feedback for the results of the test and the plan to move ahead with gender dysphoria evaluation.

New issues/stressors/extraordinary events presented today: None reported

Goals, Objectives, and Interventions Addressed Today

Goal Today	Objective Today
Determine whether the offender meets criteria for gender dysphoria / determine appropriate treatment	Gather history and report of past and present symptoms that may support a diagnosis of gender dysphoria

Interventions/Methods Provided:
Psychologist informed offender of MMPI results being received. Reviewed the test profile, explained the scales of the profile to offender Richardson, and reviewed some initial points of profile interpretation with her. Explained the psychologist's view of the next directions to take with the ongoing evaluation for diagnosis and possible treatment of gender dysphoria.
Response to Interventions/Progress Toward Goals and Objectives:
Stable. Engaged.

Current Assessment

Individual's progress: Some progress

Assessment:
Anxiety is not significant. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is not significant. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. Patient is responding to treatment plan. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

Risk Assessment

CURRENT ENCOUNTER

Risk Assessments
Patient denies suicidal ideation, plan, intent, and/or attempt.
Patient denies property damage ideation, plan, intent, and/or attempt.
Patient denies homicidal ideation, plan, intent, and/or attempt.

RISK ASSESSMENT HISTORY

Risk	Current	Past	Documented	Event Date	Approximate Date	Ideation	Plan	Intent	Scale
Suicide	Denies		04/28/2020	04/28/2020	No				
Property	Denies		04/28/2020	04/28/2020	No				
Homicide	Denies		04/28/2020	04/28/2020	No				

Attempt	Planned/ Impulsive	Drug/Alcohol Influenced	Medically Treated	Plan Attempt Description

SAFETY MANAGEMENT PLAN

No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

Assessment/Diagnosis

AXIS IV

Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V

Current GAF: 68

Date: 04/28/2020.

Highest GAF: 68

Date: 02/25/2020.

Plan and Additional Information

Date	Order Description
05/19/2020	MHP follow-up for Ind Tx

SIGNATURES

Staff: Signed by Richard J. Gale, PsyD, HSPP on 04/28/2020

Behavioral Health Billing

Start time: 2:10 PM
End time: 3:00 PM
Duration: 00 hours, 50 minutes
Modifier: N/A

Document generated by: Richard J. Gale, PsyD 04/28/2020 05:13 PM

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Facility: CIC

PATIENT: JONATHAN RICHARDSON
DATE OF BIRTH: [redacted]
DATE: 04/08/2020 10:32 AM
VISIT TYPE: Chronic Care Visit

History of Present Illness:

1. asthma
   The initial visit date was 02/12/2008. Symptoms of asthma began in 1984. Pertinent negatives include awakening with cough, awakening with dyspnea, awakening with wheeze, dry cough, dyspnea at rest, dyspnea with intense exercise, dyspnea with moderate exercise, excessive sputum, hemoptysis, hoarseness, irregular heartbeat/palpitations, mucus plug production, oral thrush, pleuritic pain, post nasal drainage, productive cough, reflux, seasonal rhinitis symptoms, sinusitis, stridor, tremor after inhaler use and wheezing.

PROBLEM LIST:

Problem Description	Onset Date	Chronic	Clinical Status	Notes
Gastroesophageal reflux disease	02/19/2015	Y		Mapped from KBM Chronic Conditions table on 05/09/2016 by the ICD9 to SNOMED Bulk Mapping Utility. The mapped diagnosis code was Esophageal reflux, 530.81, added by Paul A. Talbot, MD, with responsible provider Paul A. Talbot MD. Onset date 02/19/2015.
Borderline personality disorder	05/04/2010	Y		Mapped from KBM Chronic Conditions table on 05/09/2016 by the ICD9 to SNOMED Bulk Mapping Utility. The mapped diagnosis code was Borderline personality disorder, 301.83, added by Darla Hinshaw, MD, with responsible provider . Onset date 05/04/2010; Axis II.
Recurrent major depressive episodes, mild	10/21/2019	N		

Problem List (not yet mapped to SNOMED-CT®):

Problem Description	Onset Date	Notes
Asthma	03/19/2007	

RICHARDSON, JONATHAN 127630 [redacted] 04/08/2020 10:32 AM 144/182

Polysubstance Dependence	01/17/2011
major depression in remission	01/17/2011
Nonspecific reaction to tuberculin skin test witho	02/01/2011
Epilepsy	06/11/2015

Allergies

Ingredient	Reaction	Medication Name	Comment
IBUPROFEN	Rash		
PENICILLINS	Rash		
CEFTRIAXONE SODIUM	SOB, chest pressure, rash	ROCEPHIN	Pt was given 0.5mg Epi x1 and NS IV w/ good results

Review of Systems

System	Neg/Pos	Details
ENMT	Negative	Hoarseness, oral thrush, post-nasal drainage and sinusitis.
Respiratory	Negative	Awakening with cough, awakening with dyspnea, awakening with wheezing, dry cough, dyspnea at rest, dyspnea with intense exercise, dyspnea with moderate exercise, excessive sputum, hemoptysis, mucus plug production, pleuritic pain, productive cough, stridor and wheezing.
Cardio	Negative	Irregular heartbeat/palpitations.
GI	Negative	Reflux.
Endocrine	Negative	Tremors.
Allergic/Immuno	Negative	Seasonal rhinitis symptoms.

Vital Signs

Height

Time	ft	in	cm	Last Measured	Height Position
10:33 AM	5.0	11.0	0.0	02/08/2014	0

Weight/BSA/BMI

Time	lb	oz	kg	Context	BMI kg/m2	BSA m2
10:33 AM	218.0		98.883	dressed with shoes	30.40	

Blood Pressure

Time	BP mm/Hg	Position	Side	Site	Method	Cuff Size
10:33 AM	110/74	sitting	right	wrist	automatic	adult large

Temperature/Pulse/Respiration

Time	Temp F	Temp C	Temp Site	Pulse/min	Pattern	Resp/ min
10:33 AM	98.30	36.8	oral	88		16

Pulse Oximetry/FIO2

Time	Pulse Ox (Rest %)	Pulse Ox (Amb %)	O2 Sat	O2 L/Min	Timing	FiO2 %	L/min	Delivery Method	Finger Probe
10:33 AM	97								

Peak Flow

RICHARDSON, JONATHAN 127630 [redacted] 04/08/2020 10:32 AM 145/182

Time	PeakFlow L/min	Timing	Method
10:35 AM	300		
10:35 AM	320		
10:33 AM	350		

Measured By

Time	Measured by
10:35 AM	Linda S. Stewart, MA
10:35 AM	Linda S. Stewart, MA
10:33 AM	Linda S. Stewart, MA

Physical Exam

Exam	Findings	Details
Constitutional	*	Overall appearance - Appears well.
Eyes	Normal	Conjunctiva - Right: Normal, Left: Normal.
Ears	Normal	Inspection - Right: Normal, Left: Normal. Hearing - Right: Normal, Left: Normal.
Neck Exam	Normal	Inspection - Normal. Palpation - Normal.
Respiratory	Comments	Airmovement improved. minimal wheeze and it is much improvement for him compared to last year.
Respiratory	Normal	Inspection - Normal. Effort - Normal.
Cardiovascular	Normal	Regular rhythm. No murmurs, gallops, or rubs.
Vascular	Normal	Pulses - Dorsalis pedis: Normal. Capillary refill - Less than 2 seconds.
Abdomen	Normal	Inspection - Normal.
Musculoskeletal	Normal	Visual overview of all four extremities is normal.
Extremity	Normal	No edema.
Neurological	Normal	Memory - Normal. Cranial nerves - Cranial nerves II through XII grossly intact.
Psychiatric	Normal	Orientation - Oriented to time, place, person & situation. Appropriate mood and affect.

Assessment/Plan

#	Detail Type	Description
1.	Assessment	Asthma (493).
	Impression	Mild intermittent. Pt states that he works at bakery section of kitchen and does not get exposed to chemical as used to last year. Pt has not used nebulizer tx for several months either. Lung sound much better than used to. will d/c Nebulizer Tx..
2.	Assessment	Hypercholesterolaemia (272.0).
	Impression	Diet control. Exercise recommended..

Medications *(Added, Continued or Stopped today)*

Start Date	Medication	Directions	PRN Status	PRN Reason	Instruction	Stop Date
04/08/2020	Xopenex HFA 45 mcg/actuation aerosol inhaler	inhale 2 puff by inhalation route every 6 hours, as needed.	N			10/04/2020

Provider:
Savino, Yoko 04/08/2020 10:56 AM
Document generated by: Yoko Savino, MD 04/08/2020 10:55 AM

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Indianapolis, IN 46204

Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	04/07/2020 5:18 PM
HISTORIAN:	self
VISIT TYPE:	Onsite Consult

Individual Counsel/Psych Prog Note

General

Program Name: Outpatient

Start time: 1:15 PM

End time: 00 hours, 35 minutes

Duration: 00 hours, 35 minutes

Individuals Present/Support Resources

Contact type:
Onsite
Individual present.

MENTAL STATUS EXAM
GENERAL OBSERVATIONS:
Generally normal
Appearance:Within normal limits
Build/Stature: Within normal limits
Posture: Within normal limits
Eye Contact: Average
Activity: Within normal limits
Attitude toward examiner: Cooperative
Attitude toward parent/guardian: Not Applicable
Separation (for children/adolescent): Not applicable

MENTAL STATUS:
Unremarkable
Mood: Euthymic
Affect: Full

Speech: Clear
Thought process: Logical
Perception: WNL
Hallucination: Denied None evidenced
Thought content: Within normal limits
Delusions: None Reported
Cognition: Within normal limits
Intelligence estimate: Average
Insight: Within normal limits
Judgment: Within normal limits

Subjective Information

Individual's report of progress towards goals/objectives since last session:
Ofd. seen fo rregular follow-up therapy appointment. She reports no new concerns. She had several questions about the psychiatric assessment for Gender Dysphoria that occurred last week. She reports that she is still working as a baker in the kitchen and is deriving a lot of pleasure and meaning from this position. She discussed in detail how she has improved several of the desserts she has been making and the positive feedback she has gotten. Denies SI or HI.

New issues/stressors/extraordinary events presented today: None reported

Goals, Objectives, and Interventions Addressed Today

Goal Today	Objective Today
Alleviate depressive symptoms	Verbalizes increased feelings of self worth

Interventions/Methods Provided:
Psychologist provided what limited feedback he could to the offender regarding the psychiatric eval last week. Discussed the delays in getting back MMPI results to help with the ongoing GD eval. Processed the pride offender is taking in her work and the sense of purpose that it creates. Reinforced the boost in self-esteem that it has caused.
Response to Interventions/Progress Toward Goals and Objectives:
Stable. Doing well.

Current Assessment

Individual's progress: Good progress

Assessment:
Anxiety is not significant. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is not significant. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. Patient is responding to treatment plan. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

Risk Assessment

CURRENT ENCOUNTER

Risk Assessments
Patient denies suicidal ideation, plan, intent, and/or attempt.
Patient denies property damage ideation, plan, intent, and/or attempt.
Patient denies homicidal ideation, plan, intent, and/or attempt.

RISK ASSESSMENT HISTORY

Risk	Current	Past	Documented	Event Date	Approximate Date	Ideation	Plan	Intent	Scale

Suicide	Denies	04/07/2020	04/07/2020	No
Property	Denies	04/07/2020	04/07/2020	No
Homicide	Denies	04/07/2020	04/07/2020	No

Attempt	Planned/ Impulsive	Drug/Alcohol Influenced	Medically Treated	Plan Attempt Description

SAFETY MANAGEMENT PLAN
No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

Assessment/Diagnosis

AXIS IV
Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V
Current GAF: 68
Date: 04/07/2020.

Highest GAF: 68
Date: 02/25/2020.

Plan and Additional Information

Date	Order Description
04/28/2020	MHP follow-up for Ind Tx

SIGNATURES

Staff: Signed by Richard J. Gale, PsyD, HSPP on 04/07/2020

Behavioral Health Billing

Start time: 1:15 PM
End time: 1:50 PM
Duration: 00 hours, 35 minutes
Modifier: N/A

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